Reset Fields

BRISTOL-MYERS SQUIBB PATIENT ASSISTANCE FOUNDATION, INC.

Individual Patient Assistance Program

P.O. Box 1058 I Somerville, NJ 08876 I Phone: (800) 736-0003 I Fax: (800) 736-1611

PATIENT INFORMATION TO BE COMPLETED BY PATIENT OR LEGAL GUARDIAN

First Name:	MI:	Last Name:	Date of Birth:
Mary Jo		Doe	01/12/1956

Mailing Address:	Apt #:
1234 Mack Ave	1234

City:	State:	Zip Code:
Detroit	MI	48963

Social Security Number:	Gender Male/Female:	Phone #:
555-55-5555	Female	(313) 999-9999

PATIENT ELIGIBILITY INFORMATION – ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME (REQUIRED)

TOTAL ANNUAL HOUSEHOLD INCOME (Include all Income, Wages, Social Security, Pension, Disability, Interest Earned on Savings, etc.) $32900 **ANNUAL**

Number of people in household: 4	Is patient currently enrolled in a Medicare Part D Prescription Drug Plan? **Yes** ☐ **No** ■
Does patient have public or private prescription drug coverage? **Yes** ☐ **No** ☐	Is patient a U.S. Citizen or legal resident? **Yes** ■ **No** ☐

I attest that the above information is complete and accurate. I attest that I have no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or any other public or private program, and I have insufficient financial resources to pay for the prescribed therapy. By my signature, I authorize the release of the information about me and my medical condition to the Bristol-Myers Squibb Patient Assistance Foundation (BMSPAF) and/or their agents. I authorize the BMSPAF and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the BMSPAF and administration of the BMSPAF, which may include contacting my insurer, public funding programs, social workers, advocacy organizations, healthcare providers, or other persons or entities the BMSPAF may deem appropriate to release all medical records or requested information bearing on my eligibility to and benefits under the program. Additionally, I agree that at any time during my enrollment, the BMSPAF may request additional documentation to authenticate the statements made on my application. The BMSPAF and/or their agents agree not to disclose any information to any third party except as authorized by me or as required by law. I understand and acknowledge that this assistance is temporary and that this program may be changed or discontinued at any time without notice.

Patient Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION; TO BE COMPLETED BY THE PRESCRIBING PRACTITIONER

First Name:	Last Name:	Professional Designation:
Joe	Brown	MD

DEA# (If not available, please provide copy of State License):	State License # :
bb12345678	315154651321

Facility Name: EACPHS

Shipping Address (Drugs cannot be shipped to the patient or P.O. Box)
1234 Mack Ave

City:	State:	Zip Code:
Detroit	MI	48963

Contact Name:	Phone Number:	Fax Number:
Sam Anderson	(313) 333-3333	(313) 444-4444

Mailing Address: (If different than shipping address)
1234 Mack Ave

City:	State:	Zip Code:
Detroit	MI	48963

PLEASE INCLUDE NO MORE THAN TWO PRODUCTS I IT IS NOT NECESSARY TO ATTACH A PRESCRIPTION

Drug Name:	Strength:	Quantity Per Day:
Plavix	75mg	1
Drug Name:	Strength:	Quantity Per Day:

Is this a change in dose schedule for an existing BMSPAF member? **Yes** ☐ **No** ☐

I represent that all information I have provided about this patient is complete, accurate and consistent with applicable privacy laws and regulations, and I understand that the BMSPAF and/or their agents are relying on this information. To the best of my knowledge, this patient has no prescription insurance coverage for the indicated medication, including Medicaid, Medicare or other public or private programs. I acknowledge and agree not to submit an insurance claim or other claim for payment to any third-party payor (private or government) for the medication. I understand that BMSPAF reserves the right to modify or terminate this program at any time. My signature certifies that the medication received from BMSPAF will not be resold nor offered for sale, trade or barter and will not be returned for credit. I further certify that no reimbursement of the cost of product has been/will be accepted by me for any treatments where product has been/will be provided free-of-charge by BMSPAF, including any product that has already been administered to the patient and for which replacement product will be provided to me. I understand that BMSPAF reserves the right to recall or discontinue product at any time without notice.

Provider Signature: _____ Date: _____